Representing Minnesota's EMS Professionals

June 27, 2002

Office of the Secretary
Federal Communications Commission
445 SW 12th Street, Suite TW-A325
Washington, DC 20554

RE: Rural Health Care Support Mechanism (WC Docket #02-60; FCC 02-122)

The following comments are submitted on behalf of the 200 ambulance service members of the Minnesota Ambulance Association in reference to the Federal Communications Commission (FCC) Notice of Proposed Rule Making regarding the Rural Health Care Universal Service Program.

A. Eligible Health Care Providers

Rural ambulance services that are located in or serve rural areas must be allowed to participate in the program

Ambulance service reimbursement under the federal Medicare program changed dramatically on April 1, 2002. Over the next 4 years, ambulance services will be transitioned to a fee schedule. In addition, the Medicare Ambulance Fee Schedule Final Rule requires that ambulance providers accept Medicare's allowed payments as payment in full.

Nationally, half of all ambulance transports are for Medicare beneficiaries. Since there are a disproportionately larger number of elderly in rural America, rural ambulance runs are also disproportionately Medicare-related when compared to urban ambulance services. The Medicare-related ambulance business for some rural Minnesota ambulance services exceeds 80%, while in the Twin Cities, the proportion is closer to 30%. Fee schedules are volume-dependent payment methodologies, a concept that also causes disproportionate difficulties for rural ambulance services.

Rural ambulance services are struggling to survive. We are encouraging a number of local approaches to deal with this problem, but we have also begun searching for other federal programs that may assist ambulance providers, as well as trying to refine ways in which service in delivered. This means we are seeking new funding streams, trying to access federal programs from which we have been excluded and refining the core structure of the service. For example, we are exploring methods to reduce the cost of initial and refresher training through distance learning. We are moving many of our communications methods to the internet. Our state EMS office is creating a new data set, on which the chief method of data entry for low-volume providers will be the internet.

In order to realize any of these efficiencies to help keep rural ambulance services capable of caring for a community in this era of devastating revenue declines, we must look to technology for assistance. While access to this program alone will not allow a rural ambulance to achieve financial independence and stability, it will be a critical link in the "chain of survival" for rural ambulance services. *We strongly urge you to change this rule and provide access to the program for all ambulance services that serve rural areas.*

B. Eligible Services

a. Internet Access

Since September 11, 2001, internet access has become critical for all health care providers, especially providers of emergency medical services. It is the primary method of delivery by federal and state agencies for information on hazards, biological or other threats and immediate warnings. Rural ambulance services, which tend to be comprised of mainly volunteers, have no other timely access to this information. They cannot travel great distances to urban centers and spend multiple days at conferences. Especially in light of last year's events, internet access for all rural ambulance services is an imperative service to include in the program.

b. Other Technologies

The technologies that are most important to rural ambulance services at this time include access to wired or wireless broadband, cellular packet data (CDPD) and the emerging GPRS.

c. Urban Area

The rules should be altered to allow cost comparisons in the largest city in a state and not be limited to a city with a population of 50,000.

C. Other Issues

a. Application Process

Many of the rural ambulance services that will apply for this program will consist of entirely volunteers. These volunteers have other full-time commitments in their community. The application process needs to be as simple and short as possible. In lieu of a burdensome and cumbersome process, it would be possible for each state-level EMS regulatory entity (in our state it would be the Minnesota Emergency Medical Services Regulatory Board – www.emsrb.state.mn.us) to provide a list of eligible rural ambulance

services to the FCC. With the states designating the eligible providers, it could eliminate work both for the FCC and the applicants.

While we just learned this program exists, we understand there is a low application rate. If you accept our ideas for change, we would encourage you to work diligently and closely with the EMS Division of the National Highway Traffic Safety Administration, the Federal Office of Rural Health Policy at HRSA in HHS, the National Association of State EMS Directors, the American Ambulance Association and the National Organization of State Offices of Rural Health to inform ambulance services about the availability of this program.

Thank you for considering our comments. We would enjoy an opportunity to discuss these issues in more detail if you so desire. Our contact is Gary Wingrove at 612.839.9991.

Sincerely.

Buck McAlpin
Minnesota Ambulance Association